DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495420	A. BUILOING _____ B. WING _____	R-C 07/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid follow-up survey to the abbreviated Standard survey of 06/07/2016 through 06/09/2016 was conducted on 07/26/2016 through 07/27/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints were also investigated during this survey. The census in this 120 certified bed facility was 87 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #101 through #109 and Resident #111) and one closed record review (Resident #110).	{F 000}	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	F 155 **1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:** Patient #101 had a Durable Do Not Resuscitate Order (DNR) dated 05/10/08 on the medical record. A Physician Order was completed indicating Resident #101 was a DNR.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jennifer J. Davis — Administrator — 8/12/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to formulate advance directives for one of 11 residents, Resident #101.

Resident #101's paper record contained a "Durable Do Not Resuscitate Order" (DNR) dated 05/10/2008. There were no orders on his current physician order sheet indicating that Resident #101 was a DNR.

Resident #101 was admitted to the facility on 02/19/2016. His diagnoses included but were not limited to: Dementia, ESRD (end stage renal disease), Type II diabetes mellitus, hypertension, heart failure, epilepsy, and chronic pain.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/16/2016. Resident #101 was assessed as having a difficulty with both long and short term memory as well as being severely impaired with daily decision making skills.

The electronic medical record (EMR) was reviewed on 07/26/2016. The POS (physician order sheet) was reviewed. Listed within the diagnoses for Resident #101 was "DO NOT RESUSCITATE". There was a diagnosis code listed beside the entry. The orders on the POS were reviewed there were no orders regarding code status listed within the orders. The care plan, the medication administration record, and

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
All current residents were audited for the presence of both the Durable Do Not Resuscitate Order and Physician Order for DNR. All remaining residents were in compliance.

3. Measures to be put in place or systemic changes made to ensure practice will not recur:
The Staff Development Coordinator/designee will in-service all charge nurses on the policy and process of initiating the Advance Directive, entering the order into the electronic record, and obtaining a physician signature for each order.

4. How facility will monitor corrective action(s) to ensure deficient practice will not recur:

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F 155	Continued From page 2	F 155	Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the QA committee quarterly times three for revisions, tracking and trending 5. Completion date August 17, 2016	

the progress note sections were reviewed. There were no entries observed regarding the resuscitation status of Resident #101.

On 07/27/2016 the paper chart was reviewed. Observed within the paper chart was a "Durable Do Not Resuscitate Order" dated 05/10/2008. The form was signed by a physician and a representative for the resident.

The DON (director of nursing) was interviewed on 07/27/2016 regarding the location of a resident's resuscitation status in the clinical record. She stated that the resuscitation status should be on the "dashboard" in the electronic record. Resident #101's electronic record was reviewed. The DON pointed to an area at the top of the screen that contained information for the resident. The information included but was not limited to, the resident's picture, date of birth, physician, and allergies. No resuscitation status was listed. She pointed to the screen, underneath the allergies and stated, "It would be right here." She was asked if orders were needed regarding resuscitation status. She stated, "We need an order for a DNR." The DON was asked what the procedure would be if no resuscitation status was listed. She stated, "The would be a full code." The DON was told that a DNR form had been located in the paper record and that "DO NOT RESUSCITATE" was listed in the diagnosis section. She stated she would look into it.

A meeting was held on 08/27/2016 at approximately 9:30 a.m. with the DON, the administrator and the corporate nurse consultant. The above information was discussed. The DON and the corporate nurse consultant stated that if a resident were to code, the EMR would be where

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F 155	Continued From page 3 staff looked for code status, not the paper chart. An end of survey meeting was held on 07/27/2016 at approximately 1:40 p.m. with the DON, the administrator and corporate staff. A new DNR form, signed and dated 07/27/2016 was presented. Per the corporate nurse consultant, Resident #101 had been a DNR at the previous facility where he resided. Upon transfer to his current facility the order for the DNR was overlooked and not written. Orders were written that day (07/27/2016) to implement the DNR status. No further information was received prior to the exit conference on 07/27/2016.	F 155		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	{F 279}	F 279 **1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:** Resident #108 had an update of the Care Plan in place for the PICC line to include all services provided by the Center. **2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:** All current residents will be reviewed to ensure a comprehensive Care Plan has been developed to include PICC line services. **3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:** The Staff Development Coordinator/designee will in-service charge nurses on the policy and procedure for Care Planning to include initiation and activation for a PICC line Care In-servicing will include developing an initial Care Plan on admission or when a PICC line is inserted during the resident's stay	

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{F 279}	Continued From page 4 under §483.10(b)(4).	{F 279}		

This REQUIREMENT is not met as evidenced by:
Surveyor: HALL, YVONNE

Based on staff interview and clinical record review, facility staff failed to develop a comprehensive care plan (CCP) for one (1) of eleven (11) residents in the survey sample, Resident #108.

Facility staff failed to develop a CCP for care of a PICC (peripherally inserted central catheter) line for Resident #108.

Findings included:

Resident #108 was admitted to the facility on 07/05/2016 with diagnoses including, but not limited to: Right Ankle Fracture with ORIF (open reduction internal fixation), Bacterial Infection, Diabetes Mellitus, Sleep Apnea, Cellulitis, Cataracts, Hypertension and Depression.

The most recent MDS (minimum data set) was an initial assessment with an ARD {assessment reference date) of 07/12/2016. Resident #108 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

The electronic medical record (EMR) for Resident #108 was reviewed on 07/26/2016 at approximately 2:40 p.m. During the record review specific physician orders were noted for care of a PICC line. Per the current POS (physician order sheet) dated July 2016: "...PICC

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:
The Unit Manager/designee will review all new admissions for new orders on PICC lines five

times a week for four weeks, weekly times two weeks, monthly times one month then, quarterly times three quarters to identify residents with a PICC line.
Any deficient practice will result in re-education or disciplinary action as indicated.
The Director of Nursing will report findings to the Quality Assurance Committee quarterly times for revision, tracking and trending.

5. Completion date August 17, 2016

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LINE dressing change upon admission and weekly and PRN (as needed)...Cefazolin Sodium Solution Reconstituted 1 (one) GM (gram) Use 2 gram intravenously every 8 hours for infection until 07/27/2016...Heparin Lock Flush Solution 100 UNIT/ML (milliliter) Use 10 unit intravenously every 8 (eight) hours for heparin lock...Normal Saline Flush Solution 0.9% (Sodium Chloride Flush) Use 10 unit intravenously every 8 (eight) hours for sash (saline/antibiotic/saline/heparin) protocol..." These physician orders were also noted on the MAR (medication administration sheet).

The CCP for this resident included the following regarding care of her PICC line: "Focus: resident receives IV (intravenous) abx (antibiotics) via PICC in upper left arm Goal: Monitor PICC site for s/sx (signs/symptoms) of infection or inflammation Interventions: change dressing per MD (physician) order" (sic) No other specific interventions were included on the CCP for care of Resident #108's PICC line.

The DON (director of nursing) was interviewed on 07/27/2016 at 10:05 a.m., during a meeting with the survey team, Administrator, Regional Nurse Consultant and Corporate Representative, regarding the CCP for Resident #108's PICC line. The DON stated, "I would expect specific interventions for care of the PICC line. I just started last Monday (meaning 07/18/2016)."

No further information was received prior to the exit conference on 07/27/2016.

{F 281} SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS {F 281}

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The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing for two of 11 residents, Resident #104 and Resident #103

1. Resident #104's 6:30 a.m. dosages of insulin were not administered on three different occasions based on fingerstick blood sugar readings. There were no parameters listed to determine when insulin dosages should not be given, nor was the physician notified of the nurse's decision to withhold the physician ordered insulin.

2. Resident #103 did not have physician ordered changes in her Parkinsonian Medications clarified and implemented until 14 days after the resident visited the neurologists office.

Findings were:

Resident #104 was admitted to the facility on 02/16/2016. His diagnoses included, but were not limited to Paraplegia, Type 2 Diabetes Mellitus, hypertension, heart failure, glaucoma and neurogenic bladder.

The most recent MDS {minimum data set} was a quarterly assessment with an ARD (assessment reference date) of 05/05/2016. Resident #104 was assessed as having a cognitive summary score of "15", indicating no impairment with his cognitive status.

1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:
Resident #104 had parameters ordered by the physician to determine when the insulin dosages should not be given and when to notify the physician with any deviation from the order.

Resident #103 received clarification and implementation on the order change for the Parkinsonian Medications.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
All the current residents were reviewed to identify potential consult order changes that failed to meet and/or follow professional standards of nursing practice or departed from appropriate care such as:

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The electronic medical record (EMR) was reviewed on 07/26/2016. The POS (physician order sheet was reviewed). Orders listed included but were not limited to: "Accuchecks BID two times a day related to TYPE 2 DIABETES MELLITUS..., MetFORMIN HCL Tablet 500 mg Give 1 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS...; NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML [milliliter]...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...; NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 32 unit subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS...; NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS..." There were no blood sugar parameters or guidelines ordered for withholding insulin.

The MAR (medication administration record) was then reviewed. Resident #104's morning dosage of insulin (NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS) was scheduled to be given at 6:30 a.m. The dosage of insulin scheduled to be given with meals (NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS) was scheduled for 6:30 a.m., 12:15 p.m., and 5:30 p.m. The twice a day Accuchecks were scheduled for 6:30 a.m. and 4:30 p.m.

The documentation on the MAR for both morning doses of Novolog insulin (30 units of Novolog 70/30 and 5 units of Novolog Solution) on 07/20/2016, 07/22/2016 and 07/23/2016 was "5"

1. Following physician orders
2. Communicating order changes to the physician
3. Adhering to Center policy and procedure
4. Documentation of the appropriate information in the medical record
5. Administering medications as ordered.

All identified areas of non-compliance will result in re-education of the involved nurse.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:
The Staff Development Coordinator/designee will in-service nurses on providing services that meet professional standards of nursing practice and/or that does not depart from appropriate care such as:

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and a nurse's initials. The coding for the MAR was reviewed. The chart code listed for "5" was: "Hold/See Progress Notes".

The progress note section was then reviewed. The following entries were observed:

"07/20/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 mix insulin was held d/t [due to] FSBS [fingerstick blood sugar - Accuchecks] at 160 at 0620 [6:20 a.m.]" There was no note regarding why the 6:30 a.m. dosage of Novolog 5 units, was not given.

"07/22/2016 Novolog Solution 100 UNIT/ML Inject 5 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS...Scheduled Novolog held d/t FSBS at 170"

"07/22/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 insulin held d/t FSBS at 170"

"07/23/2016 Novolog Solution 100 UNIT/ML Inject 5 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS...Scheduled Novolog held d/t FSBS at 167"

"07/23/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 held d/t FSBS at 167."

There was no documentation in the progress note

1. Following physician orders
2. Communicating order changes to the physician
3. Adhering to Center policy and procedure
4. Documentation of the appropriate information in the electronic medical record
5. Administering medications as ordered.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-cur:

The Director of Nursing/designee will review the 24 hour report and new orders five times a week for four weeks, weekly times two week, monthly times one month then, quarterly times three to identify any departure from appropriate care relating to following professional standards of nursing practice.

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section that the physician had been notified of the nurse's decision to withhold regularly scheduled morning doses of insulin based on the morning Accuchecks readings.

On 07/26/2016 the unit manager, RN (registered nurse) #1 and the DON (director of nursing) were interviewed regarding the nurse's decision to withhold the morning doses of insulin on three separate occasions for Resident #104. They were asked if there were standing orders or a policy regarding when insulin should be held based on Accuchecks readings. The DON stated, "We should have parameters written...if not we should have notified the physician." The DON was asked if she would have held insulin based on the blood sugar readings listed in the progress notes. She stated, "No, not for that...usually you have parameters like greater than 400 or less than 60 to call the doctor..." The unit manager stated, "We don't have standing orders to hold insulin." The DON also stated, "We will talk to the nurse tonight and find out what happened." The DON was asked if the physician had been notified would she expect to see documentation indicating that. She stated, "Yes."

On page 419, Fundamentals of Nursing Potter and Perry, Chapter 22, Legal Implications of Nursing Practice, "Physicians' Orders: The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary....In a malpractice lawsuit against a physician and a hospital one of the most frequently litigated

The Unit Manager/designee will review any consults for new orders and physician communication or clarification of those orders and for any omission of documentation on the eMAR (electronic medication administration record) with proper notification to the physician of that omission.
Any deficient practice will result in re-education or disciplinary action as indicated.
The Director of Nursing will report findings to the Quality Assurance Committee quarterly times three for Revision, tracking and trending.

5. Completion date August 17, 2016

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issues is whether the nurse kept the physician informed of the client's condition..." (1)

On 07/27/2016 a meeting was held at approximately 1:40 p.m., with the DON, the unit manager, the administrator and the corporate staff present at the facility. The above information was discussed. The unit manager stated that they had tried to reach the nurse who had held the insulin but she was not answering her phone and had not shown up for work on 07/26/2016. The unit manager stated, "I contacted [name of physician] about the insulin not being given on those dates. He said that he would have agreed with the nurse's decision to not give the insulin." She presented a note that she had written at 8:37 a.m. which read: "7/27/2016 08:37 Communication with [name of physician] revealed that [name of physician] would have agreed with the nurse on 7/19. 7/20, 7/22 and 7/23 to hold insulin due to blood sugar results and the fact that resident would not be having breakfast until after 0800. [Name of physician] informed writer that his main concern for this resident is hypoglycemia. [Name of physician] has changed the 0630 order time for accuchecks and insulin administration to 0800."

The DON was asked how long the facility staff had to notify the physician that an order such as insulin had been omitted. The corporate nurse consultant stated, "It should be within 24 hours, but for insulin it should have been at the time it happened."

No further information was obtained prior to the exit conference on 07/27/2016.

(1) Potter, Perry. Fundamentals of Nursing

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Practice, 6th Edition. Mosby. St. Louis, Missouri. 2005.

2. Resident #103 did not have physician ordered changes in her Parkinsonian Medications clarified and implemented until 14 days after the resident visited the neurologists office.

Findings were:

Resident #103 was admitted to the facility on 03/19/2016. Her diagnoses included but were not limited to: Parkinson's disease, anxiety, depression, and hypertension.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/25/2016. Resident t#103 was assessed as having a cognitive summary score of "15', indicating she was cognitively intact.

Initial tour of the facility was conducted on 07/26/2016. Resident #103 was observed sitting in her room. She was asked how she was feeling. She stated, "Not too good, I am having an allergic reaction to some of my medications that they changed." A staff member in the room immediately left and returned within one to two minutes and stated, "I just asked the nurse, she said her medications are fine and there is no reaction."

The electronic medical record was reviewed on 07/27/2016. The POS {physician order sheet) contained the following orders:
"Carbidopa-Levodopa Tablet 25-100 mg [milligrams] Give 1 tablet by mouth five times per day related to PARKINSON'S DISEASE.

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Administer with Sinemet @ [at] 0700, 1200, & 1430 [2;30 p.m.]" The order date and the start date for that medication was 07/25/2016. Also observed was: "Sinemet CR Tablet Extended Release 25-100 mg (Carbidopa-Levodopa ER [extended release]} Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE Administer with Levodopa 25/100 at 0700, 1200, 1430 doses. The order date for this medication was 07/25/2016 and the start date was 07/26/2016.

The progress note section was reviewed. A note dated 07/24/2016 was observed which read, "Resident attended appt [appointment] with [name of hospital] Neurology on 07/12/2016 with [name of physician] with orders to start sinemet 25/200 one tab at 0700, 0930, 1200, 1430, 1700. 1930 and sinemet CR 25/200 to be administered with the regular 25/100 at 0700, 1200, and 1700 times, RP [responsible party] is aware."

LPN (licensed practical nurse) #2 was interviewed on 07/27/2016 at approximately 8:30 a.m. regarding Resident #103's medications. She stated, "I wrote that note...I found her consult from the neurology clinic in a folder at the desk...the times on the consult sheet and the orders they sent didn't match so we had to get clarification...I saw that we hadn't done that yet, so I called them." LPN #2 was asked if she had gotten the clarification. She stated, "Yes, I guess I just pushed a little harder to get it."

A meeting was held on 07/27/2016 at approximately 9;00 a.m., with the DON (director of nursing}, the administrator and the corporate nurse consultant. The above information was discussed. The DON stated that calls had been

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made to the neurology clinic for order clarification but nothing had been documented. She stated that a fax was eventually sent in an attempt to get orders clarified. The DON was asked what the expected time frame for follow up on order clarification should be. She stated, "We should follow up as soon as possible." The DON was asked if she felt that the 13-14 day time frame for the implementation of the changes recommended by the neurology clinic was acceptable. She shook her head side to side indicating, "No." The DON was asked if the attempts to clarify the medication should have been documented. She stated, "Yes."

The Lippincott Manual of Nursing Practice 10th edition states on page 16 regarding standards of nursing care, " A deviation from the protocol should be documented in the patient ' s chart with clear, concise statements of the nurse ' s decision, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events. " (1)

No further information was obtained prior to the exit conference on 07/27/2016.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

{F 309} SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING {F 309}

Each resident must receive and the facility must provide the necessary care and services to attain

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to follow physician orders for two of 11 residents in the survey sample, Resident #106 and Resident #104.

1. Facility staff failed to check fingerstick blood sugars (FSBS) per physician order for Resident #106.

2. Resident #104's 6:30 a.m. physician ordered insulin dosages were not administered on three different occasions based on fingerstick blood sugar readings. On 07/26/2016 the medication nurse did not perform the accucheck or administer the physician ordered insulin.

Findings included:

1. Facility staff failed to check fingerstick blood sugars (FSBS) per physician order for Resident #106.

Resident #106 was admitted to the facility on 06/15/2016 with diagnoses including, but not limited to: Right Hip Fracture with ORIF (open reduction internal fixation), Diabetes Mellitus, Dementia without Behaviors, Atherosclerotic Heart Disease, hypertension, Depression, Sleep Apnea and Infection.

1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:

Resident #106 Accucheck order for AC and HS was discontinued when MD contacted. Nurse responsible for inputting order has been re-educated.

Resident # 104 Blood sugar checks was changed from 6:30 AM to 8 AM. MD notified of insulin being held with no new orders received. Parameters were placed on diabetics with routine Blood Sugars. Nurse that held insulin was re-education

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
Residents with finger stick blood sugars have been audited to ensure orders were completed appropriately with area to document blood sugars on the MAR (Medication administration Record).

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(F 309)	Continued From page 15 The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 06/22/2016. Resident #106 was assessed as moderately impaired in her cognitive status with a total cognitive score of 08 out of 15. The EMR (electronic medical record) of Resident #106 was reviewed on 07/26/2016 at 4:30 p.m. The current POS (physician order sheet) dated July 2016 included the following: "...Accuchecks AC (before meals) and HS (bedtime). Review of flow sheets in the EMR revealed blood sugar results completely blank. Review of the MAR (medication administration sheet) revealed no documentation of any blood sugar checks. This calculated out to 33 missed opportunities for blood sugar checks. LPN #1 (licensed practical nurse) was interviewed on 07/27/2016 at 9:15 a.m. regarding blood sugar checks for Resident #106. LPN #1 pulled up the MAR for Resident #106 on the medication cart computer and stated, "It isn't on my MAR to check. Let's look at the orders." LPN #1 then pulled up physician orders for Resident #106. The orders revealed an order for Accuchecks AC and HS. LPN #1 stated, "Here is the order. It should be on the MAR." LPN #1 then pulled up the MAR for the previous 11-7 shift. No blood sugar check results were entered. LPN #1 stated, "I will get it today for sure and figure out why it isn't on the MAR. Should be checked AC and HS." At approximately 10:00 a.m., during a meeting with the survey team, Administrator, DON (director of nursing), Regional Nurse Consultant and Corporate Representative, the above	(F 309)	Residents with orders for routine blood sugars have parameters added directing nurses when to call MD (medical doctor).. All professional staff have been re-educated on inputting orders into the medical record appropriately and parameters for blood sugars, holding insulin, and when to call MD. Order listing report will be checked the next business day to ensure new orders are captured. **3. Measures to be put in place or systemic changes made to ensure practice will not recur:** The Staff Development Coordinator/designee in-serviced all nurses on correct order entry format in Point Click Care. The DON/Unit Manager/ designee will audit blood sugars and insulin orders of new resident five times a week for four week, weekly times two weeks, monthly times one week, then quarterly times three quarters on new admissions for accurate order entry format and documentation of blood sugars as ordered.	

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information was relayed to facility administration. The Regional Nurse Consultant stated, "It sounds like the order was not put in correctly." (Meaning the computer system) The DON stated, "A transcription error."

No further information was received prior to the exit conference on 07/27/2016.

2. Resident #104's 6:30 a.m. physician ordered insulin dosages were not administered on three different occasions based on fingerstick blood sugar readings. On 07/26/2016 the medication nurse did not perform the Accuchecks or administer the physician ordered insulin.

Findings were:

Resident #104 was admitted to the facility on 02/16/2016. His diagnoses included, but were not limited to Paraplegia, Type 2 Diabetes Mellitus, hypertension, heart failure, glaucoma and neurogenic bladder.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/05/2016. Resident #104 was assessed as having a cognitive summary score of "15", indicating no impairment with his cognitive status.

The electronic medical record (EMR) was reviewed on 07/26/2016. The POS (physician order sheet was reviewed). Orders listed included but were not limited to: "Accuchecks BID two times a day related to TYPE 2

4. How facility will monitor corrective action(s) to ensure deficient practice will not recur:

The Director of Nursing will report findings to the Quality Assurance Committee quarterly times three for revisions, tracking and trending.

5. Completion date August 17, 2016

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DIABETES MELLITUS..., MetFORMIN HCL Tablet 500 mg Give 1 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS...; NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML [milliliter]...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...; NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 32 unit subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS...; NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS..." There were no blood sugar parameters or guidelines ordered for withholding insulin.

The MAR (medication administration record) was then reviewed. Resident #104's morning dosage of insulin (NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS) was scheduled to be given at 6:30 a.m. The dosage of insulin scheduled to be given with meals (NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS) was scheduled for 6:30 a.m., 12:15 p.m., and 5:30 p.m. The twice a day Accuchecks were scheduled for 6:30 a.m. and 4:30 p.m.

The documentation on the MAR for both morning doses of Novolog insulin (30 units of Novolog 70/30 and 5 units of Novolog Solution) on 07/20/2016, 07/22/2016 and 07/23/2016 was "5" and a nurse's initials. The coding for the MAR was reviewed. The chart code listed for "5" was: "Hold/See Progress Notes". The area for documentation on 07/26/2016 was blank for both morning doses of insulin and the morning Accuchecks.

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The progress note section was then reviewed. The following entries were observed:

"07/20/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 mix insulin was held d/t [due to] FSBS [fingerstick blood sugar - Accuchecks] at 160 at 0620 [6:20 a.m.]" There was no note regarding why the 6:30 a.m. dosage of Novolog 5 units, was not given.

"07/22/2016 Novolog Solution 100 UNIT/ML Inject 5 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS...Scheduled Novolog held d/t FSBS at 170"

"07/22/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 insulin held d/t FSBS at 170"

"07/23/2016 Novolog Solution 100 UNIT/ML Inject 5 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS...Scheduled Novolog held d/t FSBS at 167"

"07/23/2016 NovoLOG Mix 70/30 100 UNIT/ML Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...scheduled Novolog 70/30 held d/t FSBS at 167."

There was no documentation in the progress note section that the physician had been notified of the nurse's decision to withhold regularly scheduled morning doses of insulin based on the morning

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Accuchecks readings.

On 07/26/2016 the unit manager, RN {registered nurse) #1 and the DON (director of nursing) were interviewed regarding the nurse's decision to withhold the morning doses of insulin on three separate occasions for Resident #104. They were asked if there were standing orders or a policy regarding when insulin should be held based on Accuchecks readings. The DON stated, "We should have parameters written...if not we should have notified the physician." The DON was asked if she would have held insulin based on the blood sugar readings listed in the progress notes. She stated, "No, not for that...usually you have parameters like greater than 400 or less than 60 to call the doctor..." The unit manager stated, "We don't have standing orders to hold insulin." The DON also stated, "We will talk to the nurse tonight and find out what happened." The DON was asked if the physician had been notified would she expect to see documentation indicating that. She stated, "Yes."

On 07/27/2016 a meeting was held with the DON, the unit manager, the administrator and the corporate staff present at the facility. The above information was discussed. The unit manager stated that they had tried to reach the nurse who had held the insulin but she was not answering her phone and had not shown up for work on 07/26/2016. The unit manager also stated, "I was working night shift and should have done the accuchecks and given the insulin yesterday (07/26/2016) morning...I was on the medication cart at 5:00 a.m...the computer turns the medication yellow on the screen when it is due, pink if it is overdue and if nothing is due it is white. When I signed off the cart everything was

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white, meaning nothing was due....I changed carts and when the dayshift nurse came on the previous shifts medications don't show up...It's my fault that he didn't get his Accuchecks or his insulin yesterday morning...I let the physician know last night that I missed it and I wrote a note." In regard to the omission of the insulin on the other dates in question she stated, "I contacted [name of physician] about the insulin not being given on those dates. He said that he would have agreed with the nurse's decision to not give the insulin." She presented a note that she had written at 8:37 a.m. which read: "7/27/2016 08:37 Communication with [name of physician] revealed that [name of physician] would have agreed with the nurse on 7/19. 7/20, 7/22 and 7/23 to hold insulin due to blood sugar results and the fact that resident would not be having breakfast until after 0800. [Name of physician] informed writer that his main concern for this resident is hypoglycemia. [Name of physician] has changed the 0630 order time for accuchecks and insulin administration to 0800."

No further information was obtained prior to the exit conference on 07/27/2016.

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{F 431} SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

{F 431}

1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:

Maintenance repaired the lock on the 400 unit refrigerator narcotic box.

All units and carts were immediately checked for unsecured narcotics, expired meds, and undated open

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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure that medications were properly stored in three of three medication rooms currently in use at the facility.

Medication rooms located on the 100, 200 and 400 hall contained unlabeled medications, expired medications and medicaitons that were not in a separately locked, permanently affixed compartment.

Findings were:

{F 431}

medications. Any medications found out of compliance were discarded.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
Pharmacy services audited all units and carts for unsecured narcotics, expired medications, and undated open medications. Any medications out of compliance were discarded.

3. Measures to be put in place or systemic changes made to ensure practice will not recur:
The Staff Development Coordinator/designee in-serviced all nurses on the Center policy and procedure for dating of medications, securing of medications, and discarding of expired or discontinued medications.

4. **How facility will monitor corrective action(s) to ensure deficient practice will not re-cur:**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 22 The medication rooms at the facility were inspected on 07/27/2016 beginning at approximately 1:00 p.m. The medication room on the 100 unit was observed. Contained in the refrigerator was an opened vial of PPD (tuberculin test solution). The vial was dated 05/28/2016. The DON (director of nursing) was in the room with this surveyor. The DON was asked if the date indicated the date the vial was open or the date it was to be disposed of. She stated, "I would think the date opened." The DON was asked how long the vial could be used after being opened. She stated, "I would think until the manufacturer's expiration date." Also contained in the refrigerator was an unopened bottle of Nystatin which had a pharmacy expiration date of 07/20/2016. The DON was asked if the resident who the medication was prescribed for was still at the facility. She stated, "Yes." The medication room on the 400 unit was then inspected. Observed in the refrigerator was a bottle of liquid Omeprazole which expired on 07/22/2016. The resident the medication was prescribed for was still at the facility. The medication room on the 200 unit was then inspected. An opened bottle of flu vaccine was observed. There was no date on the vial. LPN (licensed practical nurse) #1 stated, "I will throw that away...we haven't given those vaccines since the end of March." Also observed in the refrigerator was a "Hospice Kit." The resident listed on the kit was no linger residing in the facility. Contained in the kit was one 15 ml (milliliter) bottle of morphine and 10 tablets of .5	{F 431}	The Unit Manager/designee will audit each unit Medication Room and medication carts five times weekly for four weeks, weekly for two weeks, monthly for one month, then quarterly times 3 to identify and ensure narcotics are secure, expired medications are discarded, and all medications are dated when opened. Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the Quality Assurance Committee quarterly times three for revision, tracking and trending **5.** Completion date August 17, 2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	R-C 07/27/2016

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(F 431)	Continued From page 23	(F 431)		

mg (milligram) Lorazepam. The kit was laying on a shelf in the refrigerator. The refrigerator did not have a lock. LPN #1 stated, "I don't know why they didn't put that in the locked box."

During an end of the day meeting on 07/27/2016 at approximately 1:40 p.m., the above information was discussed with the DON, the corporate nurse consultant and the administrator. The DON stated, "The TB test should be thrown away after 28 days." The administrator stated that the unit manager and the night shift nurses were suppose to check the medication rooms.

A copy of the manufacturer ' s insert for the PPD testing solution was requested from the DON, but not received. According to an online search for the manufacturer ' s instructions and package insert, the following information was found:
PACKAGE INSERT
TUBERSOL®
Tuberculin Purified Protein Derivative (Mantoux)

STORAGE
Store at 2_ to 8_C (35_ to 46_F). DO NOT FREEZE. Discard product if exposed to freezing. Tuberculin PPD solutions can be adversely affected by exposure to light. The product should be stored in the dark except when doses are actually being withdrawn from the vial.
A vial of TUBERSOL® [Tuberculin Purified Protein Derivative (Mantoux)] which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency.
Failure to store and handle TUBERSOL® as recommended will result in a loss of potency and inaccurate test results.
Do not use after expiration date. (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	R-C 07/27/2016

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{F 431}	Continued From page 24	{F 431}		

(1)
https://www.vaccineshoppe.com/image.cfm?doc_id=13693&image_type=product_pdf

No further information was obtained prior to the exit conference on 07/27/2016.